Would you like to receive **Quality Views** by e-mail? If so, contact Dan Ketchum at Dketchum@hca.co.orange.ca.us and he will add your name to an electronic mailing list. Service chiefs are encouraged to include the names of all their staff who use Outlook, and periodically inform us when new staff members are hired.

Quality Views

Volume 1, Issue 4
November-December 2000

Inside this Issue

Inside the next issue

Designing a survey for maximum benefit

Performance Outcome Update

County of Orange
Health Care Agency

Juliette Poulson, RN, MN.
Interim Director, HCA

Douglas Barton
Deputy Agency Director,
Behavioral Health Services

Behavioral Health Services
Central Quality Improvement
405 W. 5th St., Suite 410
Santa Ana, CA. 92701
714-834-5601

Effective Use of Teams in Quality Improvement

- Dan Ketchum, CPHQ

In 1999, Northeast Georgia Healthcare System (NGHS) described how it developed a team to assist management in addressing customer service concerns in its organization while maintaining operational efficiency and effectiveness. Leaders (an Executive Committee) created a 20-member "Resource Team", identified priorities, established deadlines, and retained an organizational development consultant to conduct education & training as needed. The team reported monthly to the Executive Committee on results achieved and barriers to the success of their goals. Team members were chosen for their knowledge of NGHS, commitment to clinical quality, ability to solve problems and work effectively with others, and other qualities. Some of their mandates included:

- If less than 100% agreement, then 100% support
- Open-mindedness
- System commitment, not departmental

The Team developed and forwarded to the Executive Committee a list of 40 individual projects to help improve customer service goals which were prioritized and given timelines. The results of this effort were remarkable:

- Thirty-five projects were completed (seven in the first 30 days)
- Over 2700 employees received training in customer service and corporate compliance
- Significant improvements in customer satisfaction

The Resource Team was reassigned to an "on call" status after one year.

The use of teams in quality improvement has grown substantially over the years to help leaders meet new challenges such as containing costs and improving the quality and delivery of services. Organizations have used teams to improve outcomes in oncology services and psychiatric rehabilitation. A Nebraska hospital established a "24 Hour" team by decreasing the frequency of team meetings but lengthening the time for each meeting to increase efficiency and accomplish team goals in a total of 24 hours of committee meetings over a 6-month period. Teams can take many forms. Some are permanent teams (e.g. committees) whereas others may be created to solve a specific problem. Effective teams like the one at NGHS often embody specific characteristics such as:

- Ongoing involvement and support of leaders and managers to encourage success
- Use of a facilitator to keep discussions on track
- Use of an agenda and minutes to allow follow-up
- Frequent communication between team and leaders
- Team understands its goals
- Use of ground rules (e.g. no fear of rank; everyone participates and no one dominates; keep an open mind; maintain confidentiality; help find answers not fault)

When used effectively, teams increase communication and ideas

and increase employee empowerment in their work that produces enduring results. Teams that include members of diverse departments can increase empathy and understanding of others.

Using Benchmarks in Quality Improvement

- Dan Ketchum, CPHQ

A benchmark is one tool of quality management in which information, data, or other results are used by an organization to allow it to evaluate and improve its performance. According to the Agency for Healthcare Research and Quality (AHRQ), benchmarks serve "as a standard of best clinical practice against which other similar practices can be measured". Other benefits from benchmarking include:

- Disclose gaps between perceived and actual performance
- Create momentum for change
- Establish a basis for setting targets of performance
- Uncover emerging practices

Benchmarks (both performance targets and processes) can be found in literature reports from professional journals, or may be published by other healthcare organizations (e.g. other County Mental Health Departments) or by quality improvement-focused organizations such as:

- Health Care Financing Administration (HCFA)
- AHRQ
- JCAHO
- Medical Outcomes Trust
- National Institutes of Medicine (IOM)
- and many others.

The Maryland Association of Hospitals and Health Systems has published numerous national aggregate data for psychiatric care indicators. The International Benchmarking Clearinghouse offers a wealth of information (white papers, case studies, articles, etc) applicable to all types of organizations. Understanding common pitfalls of benchmarking can also help ensure success.

For example, a department concerned about hospital readmission rates might obtain information from an external source such as MHA's QIProject PSY-IV and compare its rates with a national 15-day readmission rate of 58 per 1000 discharges and a rate of 30 per 1000 discharges for 16-31 days post discharge. Department staff could then determine if their rates are better or worse than the national mean and if their rates are improving or worsening. This would help the department determine a course of action and seek ideas internally and from other sources to improve its procedures.

If you would like more information on the use of teams or benchmarking in quality improvement, or references used in these articles, please contact Central Quality Improvement.

Performance Outcome Update

- Jonathan Rich, Ph.D.

The BASIS-32 is an adult performance outcome measure routinely administered to consumers in the County mental health system. This instrument measures the consumer's perception of his or her own functioning on five scales: Relation to Self/Others, Psychosis, Daily Living Skills, Impulsive/Addictive Behavior, Psychosis and Depression/Anxiety. Items on these scales are rated by consumers on a five-point scale ranging from 0 (No difficulty) to 4 (Extreme difficulty).

Scores on the BASIS-32 were compared across three diagnostic groups: Schizophrenia, Major Depression, and Bipolar Disorder. There was no difference between diagnostic groups on the Impulsive/Addictive Behavior and Psychosis scales. All three groups gave average item ratings on these scales indicating only "a little" difficulty. On the other hand, the groups did differ on their self-ratings of Daily Living Skills, Depression/Anxiety, and Relation to Self/Others. Schizophrenic consumers gave average ratings on these three scales indicating between "a little" and "moderate" difficulty. Ratings by Bipolar consumers indicated "moderate" difficulty. The consumers diagnosed with Major Depression indicated the most distress, with average ratings indicating "moderate" to "quite a bit" of distress.

The results suggest that the consumers with psychotic disorders are experiencing less subjective distress than the depressed consumers. There are several possible explanations for this. It may be that the psychotic consumers have less insight than the depressed consumers, it may be that they have adjusted to a chronic condition, or it may be that they are in a more sheltered environment, such as a group home, so that their daily stresses and point of comparison are lower.

Analysis of Performance Outcome measures can provide information which is useful for administrative and program planning decisions. Studies such as this, comparing outcome measures for a consumer against group data, can help to clarify the meaning of these measures when evaluating an individual consumer's functioning and progress.